

March 13, 2003

Re: MDR #: M2-03-0564-01

IRO: 5055

In accordance with the requirement for TWCC to randomly assign cases to IROs, TWCC assigned your case to ____ for an independent review. ____ has performed an independent review of the medical records to determine medical necessity. In performing this review, ____ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

The independent review was performed by a matched peer with the treating health care provider. Your case was reviewed by a physician who is Board Certified in Orthopedic Surgery.

Clinical History

This female claimant injured her shoulder blade and neck in an on-the-job injury on _____. Her treatment has consisted of pain medications, anti-inflammatories, physical therapy, ultrasound, and an injection. According to the clinical history, this was helpful in decreasing her symptoms.

Disputed Services:

Neuromuscular stimulator.

Decision:

The reviewer disagrees with the determination of the insurance carrier. The reviewer is of the opinion that the neuromuscular stimulator is medically necessary in this case.

Rationale for Decision:

The reviewer does not frequently use a neuromuscular stimulator because his/her experience has been that the vast majority of patients can be treated without using this modality. However, he/she does feel it is acceptable to use this device for treatment of muscular aches and sprains.

The neuromuscular stimulator prescribed in this case was helpful to the patient in decreasing her symptoms and does fall within the definition of medical necessity.

I certify that the reviewing physician in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this care for determination prior to referral to the Independent Review Organization.

We are simultaneously forwarding copies of this report to the payor and the Texas Workers' Compensation Commission. This decision by ____ is deemed to be a Commission decision and order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of this decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within ten (10) days** of your receipt of this decision (28 Tex. Admin. Code 142.5©).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings **within twenty (20) days** of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you **five (5) days** after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5 (d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings
Texas Workers' Compensation Commission
P.O. Box 40669
Austin, TX 78704-0012

A copy of this decision should be attached to the request. The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute.

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on March 13, 2003

Sincerely,